Health Advantage
An Independent Licensee of the Blue Cross and Blue Shield Association

Small Group Gold 1000 - 1
Schedule of Benefits

This Schedule of Benefits is part of the Evidence of Coverage, Form 31-17 and is subject to all benefit terms, conditions, limitations, and exclusions contained therein.

Lifetime Maximum – per Member (all services)	No Lifetime Maximum	
Dependent Age	26	
	In-Network	**Out-of-Network**
Deductible – Individual	$1,000.00	$3,000.00
Deductible – Family (two family members must meet individual deductible to satisfy the family deductible)	$2,000.00	$6,000.00
Annual Limitation on Cost Sharing - Individual	$3,000.00	Unlimited
Annual Limitation on Cost Sharing - Family	$6,000.00	Unlimited

**The Annual Limit on Cost Sharing can be met by payments of Coinsurance, prescription drug copayments, copayments and Deductible amounts for In-Network Provider services. It cannot be met by non-covered expenses, any Coinsurance or Deductible amounts for Out-of-Network Provider services.*

COVERED BENEFITS AND SERVICES	In-Network Copayment	In-Network Coinsurance	Out-of-Network Coinsurance
Professional Services			
Primary Care Physician (PCP) Visits	$35		40% after Ded
Specialist Office Visit (consultation/evaluation only)	$55		40% after Ded
Services and procedures provided in the Specialist office other than consultation and evaluation		20%	40% after Ded
Preventive Health Services			
Immunizations (by PCP)	$0		Not Covered
Well Baby Care – through 12 months of age (by PCP)	$0		Not Covered
Well Child Exam – over 12 months of age (by PCP)	$0		Not Covered
Physical Exams – Adults (by PCP)	$0		Not Covered
Annual Routine Gynecological visit (PCP or GYN)	$0		Not Covered
Mammogram and Pap Smear, PSA	$0		Not Covered
Routine Vision Exam – Adult (one per visit per Adult Member every 2 years)	$0		Not Covered
Bone Density	$0		Not Covered
Colonoscopy Screening	$0		Not Covered
Allergy Services			
Services provided by the PCP		20%	40% after Ded
Services provided by the Specialist		20%	40% after Ded
Hospital Services			
Inpatient Services -Semi-private room.	$200 per admission	20% after Ded after Copayment	40% after Ded
Outpatient Hospital Services		20% after Ded	40% after Ded
Outpatient Surgical Services	$100	20% after Ded	40% after Ded
Emergency Care Services			
Urgent Care Office Visit (consultation/evaluation only)	$55		40% after Ded
Services and procedures provided in the Urgent Care Center other than consultation and evaluation		20%	40% after Ded

COVERED BENEFITS AND SERVICES (CONT)	In-Network Copayment	In-Network Coinsurance	Out-of-Network Coinsurance
Emergency Room Observation Services	$100 Copayment plus 20% Coinsurance (Coverage is the same for In-Network and Out-of-Network)		
Ambulance Services (Ground-limited to $1,000 / trip; Air – limited to $5,000 / trip)		50%	50%
Ambulatory Surgery Centers	$100	20% after Ded	40% after Ded
Outpatient Diagnostic Services			
Diagnostic Services - Lab and X-ray (Services and procedures performed outside PCP office)	Applicable Copayment	20% after Ded	40% after Ded
Advanced Diagnostic Imaging Services CT Scan, PET Scan, MRI/MRA, Nuclear Cardiology **Prior Approval Required**	Applicable Copayment	20% after Ded	40% after Ded
Maternity and Family Planning Services*			
Prenatal and Postnatal outpatient care (Office visit Copayment may apply first visit only)	Applicable Copayment	20% after Ded	40% after Ded
Inpatient Maternity Services	$200 per admission	20% after Ded and Copayment	40% after Ded
Infertility Counseling and Infertility Testing	50%	Not Covered	Not Covered
Infertility Treatment	Not Covered	Not Covered	Not Covered
Out-of-Network Newborn coverage limited to $2,000 per Member for all services (first 90 days after birth)			
Rehabilitation Services			
Inpatient Rehabilitation Services (Limited to 60 days per Member per Contract Year)	$200 per admission	20% after Ded and Copayment	Not covered
Outpatient Rehabilitation Services: Physical, Occupational, and Speech Therapy (Limited to 30 aggregate therapy visits per Member per Contract Year) **Note: If a service is provided by a PT, OT, ST then the PCP copay applies**	$55	20%	Not covered
Chiropractic Services (Limited to 30 aggregate therapy visits per Member per Contract Year)	$55	20%	Not covered
Cardiac Rehabilitation (limited to 36 visits per Member per Contract Year) - No coverage in Freestanding Facilities.	$55	20%	Not covered
Neurologic Rehabilitation Facility Services (Prior Approval Required) – Limited to 60 days per lifetime.	$200 per admission	20% after Ded and Copayment	40% after Ded
Habilitation Services			
Developmental Services: (Limited to a maximum of 180 units per Member per Contract Year)	$55	20%	Not covered
Outpatient Habilitation Services: Physical, Occupational, and Speech Therapy (Limited to 30 aggregate therapy visits per Member per Contract Year) **Note: If a service is provided by a PT, OT, ST then the PCP copay applies**	$55	20%	Not covered
Chiropractic Services (Limited to 30 aggregate therapy visits per Member per Contract Year)	$55	20%	Not covered
Mental Illness and Substance Abuse Services			
Inpatient Hospital Services – Semi-private room	$200 per admission	20% after Ded and Copayment	40% after Ded

COVERED BENEFITS AND SERVICES (CONT)	In-Network Copayment	In-Network Coinsurance	Out-of-Network Coinsurance
Partial Hospitalization	$200 per admission	20% after Ded and Copayment	40% after Ded
***Outpatient** (consultation/evaluation only)	$55		40% after Ded
***Outpatient** Services and procedures provided in the Specialist office other than consultation and evaluation		20%	40% after Ded
***(Must be Prior Approved by Health Advantage beyond the 8th visit.)**			
Durable Medical Equipment (DME) and Medical Supplies (Prior Approval for DME for which cost exceeds $5,000)	50%		50% after Ded
Prosthetic and Orthotic Devices and Services (Prior Approval on any device for which cost exceeds $20,000)		20% after Ded	40% after Ded
Diabetes Management Services			
Diabetic Supplies, shoes (per Medicare guidelines) and equipment	20%		40% after Ded
Diabetic Self Management Training (Allowance or Allowable Charge of $250)	$0 per program		40% after Ded
Skilled Nursing Facility (Limited to 60 Days Per Member Per Contract Year)		20% after Ded	40% after Ded
Home Health Services (Limited to 50 visits per Member per Contract Year)		20% after Ded	40% after Ded
Hospice Care (must be approved by Health Advantage)		20% after Ded	Not Covered
Dental Care Services Damage to non-diseased teeth due to accident	Applicable Copayment	20% after Ded and Copayment	40% after Ded
Reconstructive Surgery			
Correct defects due to Accident or Surgery. Children age 12 years and under for specific conditions. (Defects that could have been corrected prior to coverage are not covered)	Applicable Copayment	20% after Ded and Copayment	Not Covered
Pediatric Vision- Annual Routine Exam	$0		
(1pair of glasses with lenses/contacts per Contract Year)		20%	40% after Ded
Reduction Mammoplasty (Prior Approval Required)	50%		Not covered
Medications			
Hospital or Ambulatory Surgical Center	Applicable Copayment	20% after Ded	40% after Ded
Physician's Office (PCP only)	Applicable Copayment		40% after Ded
Retail Pharmacy (Drug Store)	$10/$40/$60		
Specialty Pharmacy	$60		
Home Infusion Therapy Pharmacy - Injectable Medications		20% after Ded	40% after Ded
Organ Transplant Services (Prior Approval Required- except kidney and cornea transplants.**)**	$200 per admission	20% after Ded	Not Covered
Medical Foods and Low Protein Modified Food Products	Applicable Copayment	20% after Ded	40% after Ded
Hearing Aid Benefits - $1,400 per ear, for each three-year period, per Member.	Applicable Copayment	0%	0%
Temporomandibular Joint Benefits	Applicable Copayment	20% after Ded	40% after Ded
Miscellaneous Health Interventions	Applicable Copayment	20% after Ded	40% after Ded

NOTE:

In-Network Services for which the Member has a Coinsurance responsibility are subject to the In-Network Deductible, in most cases.

Out-of-Network Deductible and Coinsurance amounts do not apply to the In-Network Deductible or Annual Limitation on Cost Sharing. Expenses incurred for services that exceed specific benefit limits are not applied to the Annual Limitation on Cost Sharing.

The Member is responsible for difference between billed charges and the Allowance or Allowable Charges for services covered at the Out-of-Network benefit level.

Please note that Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the service or equipment meets the Primary Coverage Criteria set out in your Evidence of Coverage.

All Covered Services are subject to the Health Advantage Allowance or Allowable Charge.